HOUSE BILL No. 1254

DIGEST OF INTRODUCED BILL

Citations Affected: IC 2-5-37; IC 6-8.1-9.5; IC 12-15.

Synopsis: Medicaid expansion and affordable care study committee. Establishes the affordable care study committee. Allows the department of state revenue to establish a procedure to set off the earned income credit and the tax refund of certain Medicaid recipients for out-of-pocket expenses owed by the recipient. Modifies Medicaid provider reimbursement rates to mirror Medicare reimbursement rates for services provided to certain Medicaid recipients. Adds Medicaid rehabilitation option services, chiropractic services, dental services, and optometric services to the Indiana check-up plan and requires certain services to be included if Medicaid is expanded. Requires the office of Medicaid policy and planning (office) to negotiate with the United States Department of Health and Human Services (HHS) for a Medicaid state plan amendment or Medicaid waiver concerning expansion of Medicaid. Requires the office of the secretary of family and social services to report to the budget committee and the public health, behavioral health, and human services interim committee (interim committee) if negotiations are unsuccessful. Requires the office to present specified information to the interim committee before August 1, 2015. Requires certain state agencies to report to the interim committee concerning a health insurance exchange in Indiana.

Effective: July 1, 2015.

Clere, Brown C, Brown T, Lehman

January 22, 2015, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 119th General Assembly (2015)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2014 Regular Session and 2014 Second Regular Technical Session of the General Assembly.

HOUSE BILL No. 1254

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 2-5-37 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]:

Chapter 37. Indiana Affordable Care Study Committee

Sec. 1. As used in this chapter, "Affordable Care Act" refers to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Sec. 2. As used in this chapter, "committee" refers to the Indiana affordable care study committee established by section 4 of this chapter.

Sec. 3. As used in this chapter, "exchange" refers to an American health benefit exchange established for Indiana under the Affordable Care Act.

Sec. 4. (a) There is established the Indiana affordable care study

committee.

(b) The committee shall study and make recommendations concerning the following:

(1) Whether Indiana should implement a state-based exchange.

(2) The current operation of the federal exchange in Indiana.

(3) The definition of "essential health benefits" for use in Indiana under the Affordable Care Act, including ensuring that the definition results in adequate benefits.

(4) Access to consumer choice of health care providers.

(5) The extent to which former Indiana check-up plan (IC 12-15-44.2) participants whose income was between one hundred percent (100%) and two hundred percent (200%) of the federal income poverty level transitioned to the federal marketplace after termination from the plan, and the health care experience of the individuals after termination from the plan.

(6) The extent to which opportunities for health insurance coverage or health care provider reimbursement were missed because participants who enrolled in a federal marketplace plan enrolled in a bronze or gold coverage plan instead of a qualified silver plan that would have entitled participants with incomes between one hundred percent (100%) and two hundred fifty percent (250%) of the federal income poverty level to cost-sharing reductions.

(c) The committee shall receive and consider annual reports from the department of insurance and the office of the secretary of family and social services concerning:

(1) the status and operation of the existing federal exchange in Indiana; and

(2) the implementation of a state based exchange in Indiana.

(d) The committee shall, not later than November 1 of each year, report the committee's findings and recommendations concerning the committee's study under subsection (b) to the legislative council in an electronic format under IC 5-14-6.

Sec. 5. The committee shall operate under the policies governing study committees adopted by the legislative council.

Sec. 6. The committee consists of the following voting members:

(1) Six (6) members of the senate:

(A) not more than three (3) of whom may be members of the same political party;

(B) at least one (1) of whom is the chairperson of the senate

health and provider services standing committee, who shall serve as chairperson in an even-numbered year;

(C) at least one (1) of whom is the chairperson of the senate insurance standing committee; and

(D) appointed by the president pro tempore.

(2) Six (6) members of the house of representatives:

(A) not more than three (3) of whom may be members of the same political party;

(B) at least (1) of whom is the chairperson of the house public health standing committee, who shall serve as chairperson in an odd-numbered year;

(C) at least one (1) of whom is the chairperson of the house insurance standing committee; and

(D) appointed by the speaker.

(3) The secretary of family and social services or the secretary's designee.

(4) The commissioner of the state department of health or the commissioner's designee.

(5) The commissioner of insurance or the commissioner's designee.

(6) One (1) member representing the insurance industry.

(7) One (1) member representing hospitals.

(8) One (1) member representing physicians.

(9) One (1) member representing an organization that advocates for senior citizens.

(10) One (1) member representing an organization that advocates for children.

(11) One (1) member with expertise in mental health services.

The president pro tempore shall appoint the members described in subdivisions (6) through (8). The speaker shall appoint the members described in subdivisions (9) through (11).

Sec. 7. The affirmative votes of a majority of the voting members appointed to the committee are required for the committee to take action on any measure, including final reports.

Sec. 8. This chapter expires December 31, 2017.

SECTION 2. IC 6-8.1-9.5-10, AS AMENDED BY P.L.103-2007, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 10. The department of revenue may charge the claimant agency a fee of fifteen percent (15%) of any funds it sets off under this chapter as a collection fee for its services. The department must bill the claimant agency in order to collect this fee. However, the department may not assess a fee:

(1) to a state agency or custodial parent for seeking a setoff to a state or federal income tax refund for past due child support; **or**

(2) for seeking a set off under section 14 of this chapter.

SECTION 3. IC 6-8.1-9.5-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 14. (a) This section applies beginning January 1, 2016, if:**

(1) the Medicaid waiver or Medicaid state plan amendment sought under IC 12-15-46-3 is approved and implemented; and

(2) the Medicaid waiver or Medicaid state plan amendment includes authorization for Indiana to set off as described in this section.

(b) As used in this section, "qualified individual" means an individual who:

(1) is a Medicaid recipient other than a recipient who receives Medicaid because the individual is aged, blind, or disabled;

(2) has an income that is less than one hundred percent (100%) of the federal income poverty level; and

(3) has not paid an out-of-pocket expense that is required under the Medicaid program.

(c) The department, in consultation with the office of the secretary of family and social services, shall establish a procedure to set off the tax refund against the amount a qualified individual owes for the qualified individual's uncollected out-of-pocket payments for health care services provided under a Medicaid waiver described in subsection (a)(1).

(d) The procedures established under this section must provide for the following set off:

(1) In the case of a qualified individual who receives the earned income tax credit under IC 6-3.1-21 for the taxable year in which the set off is applied under this section, the set off may be applied only to that part of the qualified individual's state tax refund for the taxable year that is attributable to the earned income tax credit under IC 6-3.1-21.

(2) In the case of a qualified individual who does not receive the earned income tax credit under IC 6-3.1-21 for the taxable year in which the set off is applied under this section, the set off may, except as otherwise provided, be applied to the entire amount of the qualified individual's state tax refund for the taxable year.

(e) Notwithstanding section 3 of this chapter, if the part of the tax refund to which the set off may be applied under subsection (d) is insufficient to set off the entire amount owed by the qualified individual for uncollected out-of-pocket payments for health care services provided under a Medicaid waiver described in subsection (a)(1), the remaining amount owed must carry over to subsequent calendar years until the entire amount is set off as provided in this section.

(f) The department, in consultation with the office of the secretary of family and social services, shall include with the notice provided in section 5 of this chapter an itemized description of the amount owed by the qualified individual.

(g) The department shall, to the extent practicable and except as required by the waiver described in subsection (a)(1) and except as provided by subsection (d), use the procedures specified in this chapter when implementing the set off procedure under this section.

(h) Notwithstanding any other provision of this chapter, a set off under this chapter to enforce a child support obligation has priority over a set off under this section.

SECTION 4. IC 12-15-13-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 8. (a) This section applies:**

(1) beginning January 1, 2016;

(2) if the Medicaid waiver sought under IC 12-15-46-3 is approved and implemented; and

(3) to reimbursement to Medicaid providers for services provided to a Medicaid recipient, other than a Medicaid recipient who is categorically participating in Medicaid because the recipient is aged, blind, or disabled.

(b) Notwithstanding any other law, the office shall reimburse a Medicaid provider for services provided to a recipient described in subsection (a)(3) at a reimbursement rate of:

(1) not less than the federal Medicare reimbursement rate for the service provided; or

(2) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

SECTION 5. IC 12-15-44.2-4, AS AMENDED BY P.L.160-2011, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services, **including Medicaid rehabilitation option services for qualifying individuals.**

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(15) Chiropractic services.

(16) Optometric services.

(17) Dental services.

~~(15)~~ **(18)** A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

~~(b) The plan may do the following:~~

~~(1) Offer coverage for dental and vision services to an individual who participates in the plan.~~

~~(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1).~~

~~(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan.~~

~~(d) Vision services offered by the plan must include services provided by an optometrist.~~

~~(e)~~ **(b)** The plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

~~(f)~~ **(c)** The plan may not permit treatment limitations or financial

requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

SECTION 6. IC 12-15-44.2-22, AS ADDED BY P.L.160-2011, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: Sec. 22. **(a)** The office of the secretary may amend the plan in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from passage of the Federal Patient Protection and Affordable Care Act.

(b) For any waiver to cover individuals described in subsection (a), the waiver must include coverage for the services specified in section 4 of this chapter.

SECTION 7. IC 12-15-46-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2015]: **Sec. 3. (a) The office of the secretary shall negotiate with the United States Department of Health and Human Services for amendments to the state Medicaid plan or for any Medicaid waivers to take effect January 1, 2016, that are necessary to provide coverage for individuals described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).**

(b) A waiver or state plan amendment negotiated under this section must include the following:

(1) If the federal financial participation is reduced from the levels specified in the federal Patient Protection and Affordable Care Act on January 1, 2015, or if the federal government notifies states that a reduction is to occur, automatic termination of the state plan amendment or waiver thirty (30) days after the general assembly adjourns sine die after the reduction. The termination described in this subdivision:

(A) must be included in any state plan amendment or waiver entered into under this section; and

(B) may not affect the rest of the state's Medicaid program, including Medicaid waivers, and may not count against Indiana's maintenance of effort or other similar provisions.

(2) Inclusion of federal financial participation at least at the levels specified in the federal Patient Protection and Affordable Care Act on January 1, 2015.

(3) Inclusion of, when appropriate, consumer driven principles.

(4) Inclusion of coverage for preventative care services provided at no cost to the recipient and allowance of incentives for increasing preventative care for recipients.

(5) Inclusion of personal responsibility requirements, including requiring a recipient to do any of the following:

(A) Make out-of-pocket payments related to coverage for health care expenses provided under the program through copayments.

(B) Make contributions to a health care account to be used to pay the recipient's out-of-pocket health care expenses associated with health care coverage provided as part of the recipient's participation in the program described in this section.

(C) Offset a tax credit or any other amount owed to the recipient under the recipient's tax return for out-of-pocket payments not collected related to coverage for health care expenses provided under the program to the recipient.

The office of the secretary shall provide a recipient with a statement setting forth the amount of the out-of-pocket costs the recipient is responsible for contributing for care.

(6) Inclusion of health care initiatives designed to encourage an understanding of the cost and quality of care and promote the general health and well-being of recipients, including the following:

(A) Preventative care.

(B) Weight loss.

(C) Smoking cessation.

(D) Chronic disease management.

(7) Inclusion of ways for demonstrating personal responsibility that will reduce or eliminate copayments or required contributions to a health savings account, including:

(A) Participation in wellness activities, including those described in subdivision (6).

(B) Participation in a financial literacy incentive program, which must be offered online and at the following locations:

(i) Ivy Tech Community College campuses.

(ii) Each county office of the Purdue University extension program.

(C) Participation in a qualified education or workforce training program.

(8) Inclusion of coverage for mental health and substance

abuse services, as required by the federal Patient Protection and Affordable Care Act and the federal Mental Health Parity and Addiction Equity Act (P.L. 110-343).

(9) Reimbursement of Medicaid providers at a reimbursement rate of:

(A) not less than the federal Medicare reimbursement rate for the service provided; or

(B) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

The office of the secretary may use any health care service model or health care service third party payment model in providing services for individuals described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(c) The office of the secretary may not implement a waiver or Medicaid state plan amendment negotiated under this section until the office of the secretary has developed a sustainable financing plan for the Medicaid state plan amendment or waiver and the plan has been reviewed by the budget committee.

(d) If the office of the secretary is unsuccessful or unable to negotiate with the United States Department of Health and Human Services a state plan amendment or waiver described in this section by September 1, 2015, the office shall report to the public health, behavioral health, and human services interim study committee established by IC 2-5-1.3-4(14) and the budget committee, detailing the negotiations and identifying why the office was unable to reach an agreement with the United States Department of Health and Human Services.

(e) This section expires December 31, 2016.

SECTION 8. [EFFECTIVE JULY 1, 2015] **(a) As used in this SECTION, "committee" refers to the Public Health, Behavioral Health, and Human Services interim study committee established by IC 2-5-1.3-4(14).**

(b) Before August 1, 2015, the office of Medicaid policy and planning shall present a plan to the general assembly and the committee concerning how to address the provision of health care for the following populations:

(1) Individuals who currently participate in the Indiana check-up plan (IC 12-15-44.2).

(2) Individuals who are dually eligible for the federal Medicare program (42 U.S.C. 1395 et seq.) and the Medicaid program (IC 12-15).

The plan presented to the general assembly must be in an electronic format under IC 5-14-6.

(c) This SECTION expires December 31, 2015.